

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6255

Reg. Dist. No. 116245

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Jessup R7W		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) JESSUP (RURAL)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MISSION RD		d. STREET ADDRESS MISSION RD	
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE MARY BROSENNE		4. DATE OF DEATH Month Day Year 6-24 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1881
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PATRICK F. HINES		14. MOTHER'S MAIDEN NAME ELIZABETH DONOHUE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT FREDERICK BROSENNE		Address BALTIMORE-29, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Industrial Accidents DUE TO (b) Carcinoma Intestinal-Ulcers DUE TO (c) Myo-Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 6-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5 , 19 55 , to 6-24 , 19 56 , that I last saw the deceased alive on 6/24 , 19 56 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W B Howard M.D.		DATE SIGNED 6/26/56	
PHYSICIAN'S NAME (Type) W B STSWARD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/27/56	22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM	22d. LOCATION (City, town, or county) (State) ELLICOTT CITY, MD
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville, Md		24a. REC'D BY REGISTRAR ---	24b. REGISTRAR'S SIGNATURE Frank Shipley

NAME: *W. A. ...*
AGE: *...*
SEX: *...*
RACE: *...*
DATE OF BIRTH: *...*
PLACE OF BIRTH: *...*
DATE OF DEATH: *...*
PLACE OF DEATH: *...*
CAUSE OF DEATH: *...*
MANNER OF DEATH: *...*
SIGNATURE: *...*
DATE: *...*

1

BUREAU V. S.

JUL 2 1952

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 797

06247

6256

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>22 days</u>		d. STREET ADDRESS <u>312 Montrose Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Burgus</u> Last <u>Crabson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John S. Graser</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. George W. Crabson - 312 Montrose Ave. 28</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 mos.</u> <u>yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>56</u> , to <u>June 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>56</u> , and that death occurred at <u>6:45 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving J. Taylor</u>		ADDRESS (Street, city or town, state) <u>Taylor Manor Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Irving J. Taylor, M.D.</u>		DATE SIGNED <u>6/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>6-13-56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John B. Doughran</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2.

JUN 13 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08366

6257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle CLARENCE Last EDWARDS				4. DATE OF DEATH Month June Day 21 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1892		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day worker		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W W 1		16. SOCIAL SECURITY NO. 215-10-5801		17. INFORMANT Rachel Bruce, Clarksville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH Instant							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED June 21, 1956.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Entombing		6/22/56		U. of Md. Med. School		Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE John B. Loughran E.J.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

1956 7 11

RECEIVED

6258

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Harford Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>14 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>		d. STREET ADDRESS <u>4305 Ridgewood Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Goodman</u> Last <u>Goodman</u>		4. DATE OF DEATH Month <u>JUN</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 FEBb 1882</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>W.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.S.</u>	
13. FATHER'S NAME <u>David</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ida Goodman - Same</u>	
17. INFORMANT <u>Ida Goodman - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemi-balismus</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>years</u> <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 22</u> , 19 <u>55</u> to <u>6 JUN</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 JUN</u> , 19 <u>56</u> , and that death occurred at <u>2:00 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u> DATE SIGNED <u>6 JUN 56</u>			
ACTUAL SIGNATURE <u>Irving J. Taylor</u>		M.D. <u>Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Irving J. Taylor, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maar Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc 2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>JUN 8 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John B. Loughrey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6259

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>				c. LENGTH OF STAY IN 1b <u>7 mos.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy - Rural</u>				d. STREET ADDRESS <u>Route 3 - Mt. Airy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3 - Mt. Airy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Elizabeth</u> Last <u>Grove</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1, 1863</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Clay</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Keifer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Zourie Michael</u> Address <u>1005 Savannah St. S.E. Washington, D.C.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Abdominal Malignancy</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown (Discovered Feb. 56)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>February</u> , 1956, to <u>June</u> , 1956, that I last saw the deceased alive on <u>June 18</u> , 1956, and that death occurred at <u>10:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mount Airy, Maryland</u> DATE SIGNED <u>6/22/56</u>							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-25-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Morgan Co. W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 25 1956</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. A.

JUN 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06250

6260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliecott City</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Frederick Road</u>				e. STREET ADDRESS <u>149 93rd St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALPHA N HERBERT</u>				4. DATE OF DEATH Month Day Year <u>June 22 1956</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Miami</u>		11. BIRTHPLACE (State or foreign country) <u>Oakhurst N.J.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas F. Herbert</u>				14. MOTHER'S MAIDEN NAME <u>Jennie King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beatha Herbert, Miami, Florida</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE OF ARTERIOSCLEROTIC</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ANEURYSM OF ABDOMINAL AORTA</u> (c) <u>2 hrs</u> stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George E. Durgtorf</u> EXAMINER'S NAME (Type) <u>George E. Durgtorf</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SERIAL</u>		22b. DATE THEREOF <u>6/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MENLOWRIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DORSEY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. HIGGINBOTHAM, ELLICOTT CITY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>June 23, 56</u>		24b. REGISTRAR'S SIGNATURE <u>John B. Loughran, Reg.</u> B. E. L.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6261

CERTIFICATE OF DEATH

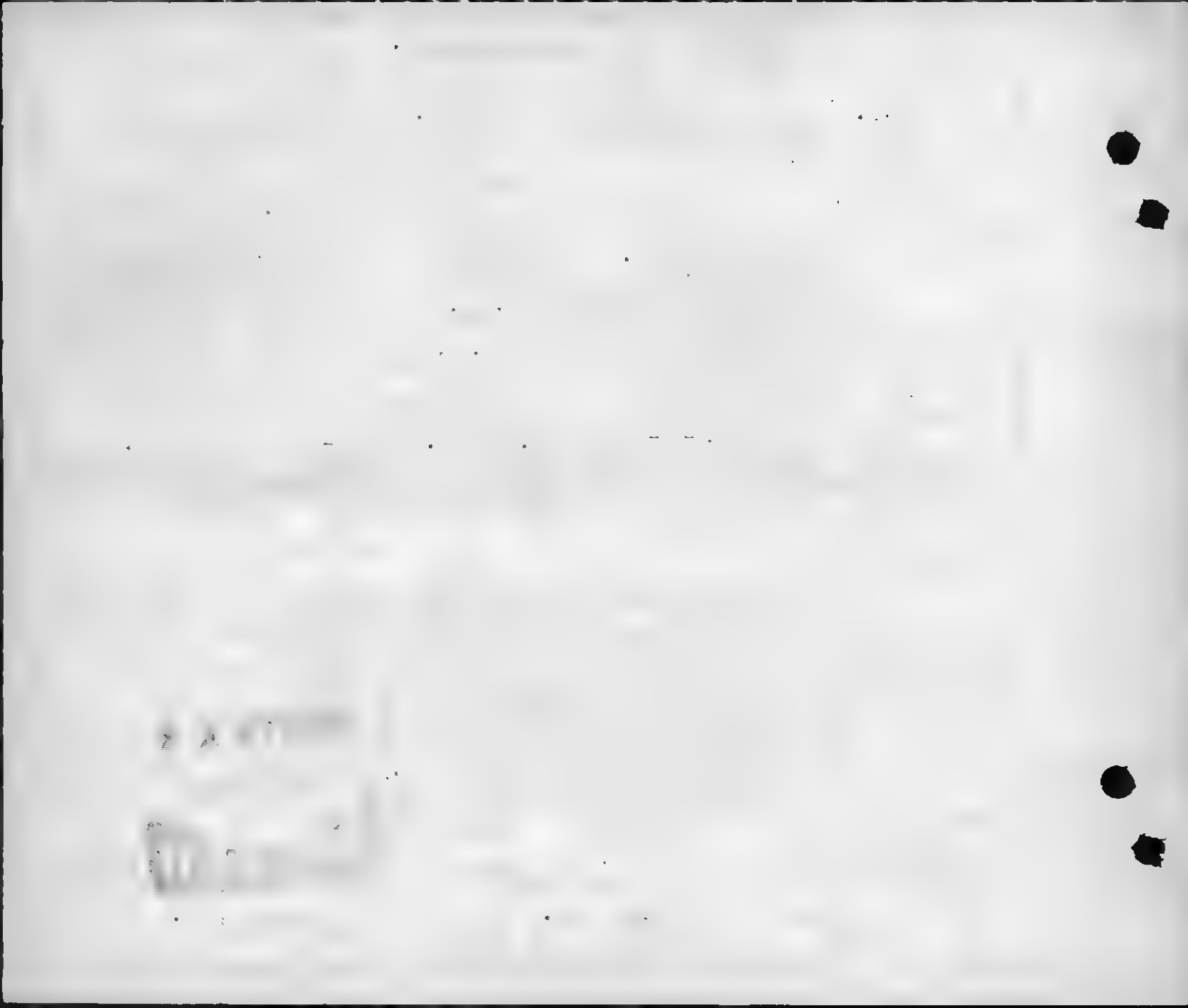
Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer's Convalescent Retreat				d. STREET ADDRESS 2307 Harlem Ave.			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle B. Last JOYNER				4. DATE OF DEATH Month June Day 9 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1871	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Jewelry				10b. KIND OF BUSINESS OR INDUSTRY N. C.		11. BIRTHPLACE (State or foreign country) N. C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Henry Joyner				14. MOTHER'S MAIDEN NAME Alice Turnage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] no		16. SOCIAL SECURITY NO. 218-09-8581A		17. INFORMANT Address Mrs. Anna N. Joyner - 2307 Harlem Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956 , to June 9, 1956 , that I last saw the deceased alive on June 6, 1956 , and that death occurred at 3 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George F. Burgtorf M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 6/11/56			
PHYSICIAN'S NAME (Type) George F. Burgtorf, M. D.				ADDRESS Ellicott City, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tichener & Sons - Balt.				24a. REC'D BY REGISTRAR DATE 6-13-56		24b. REGISTRAR'S SIGNATURE John L. Longdon	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City
OR TOWN 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church Rd. Highland Manor Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) 27 E. Cross St.
OR TOWN 27 E. Cross St.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) Elizabeth (Middle) Kern (Last)

4. DATE OF DEATH: (Month) June (Day) 18 (Year) 19 56

5. SEX:

female 6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Sept. 27, 1883

9. AGE last birthday: 72 yrs. (If under 1 year) (If under 24 hrs.) Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Tavern Operator-Self-Employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Martin

Manning

14. MOTHER'S MAIDEN NAME:

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

none

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Albert Clayland-Son-27 E. Cross St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Myocardial Insufficiency
Arterio sclerosis
Myocarditis

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 19 56, to June 18, 19 56, that I last saw the deceased

alive on June 15, 19 56, and that death occurred at

SIGNATURE

(Degree or title)

from the causes and on the date stated above.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

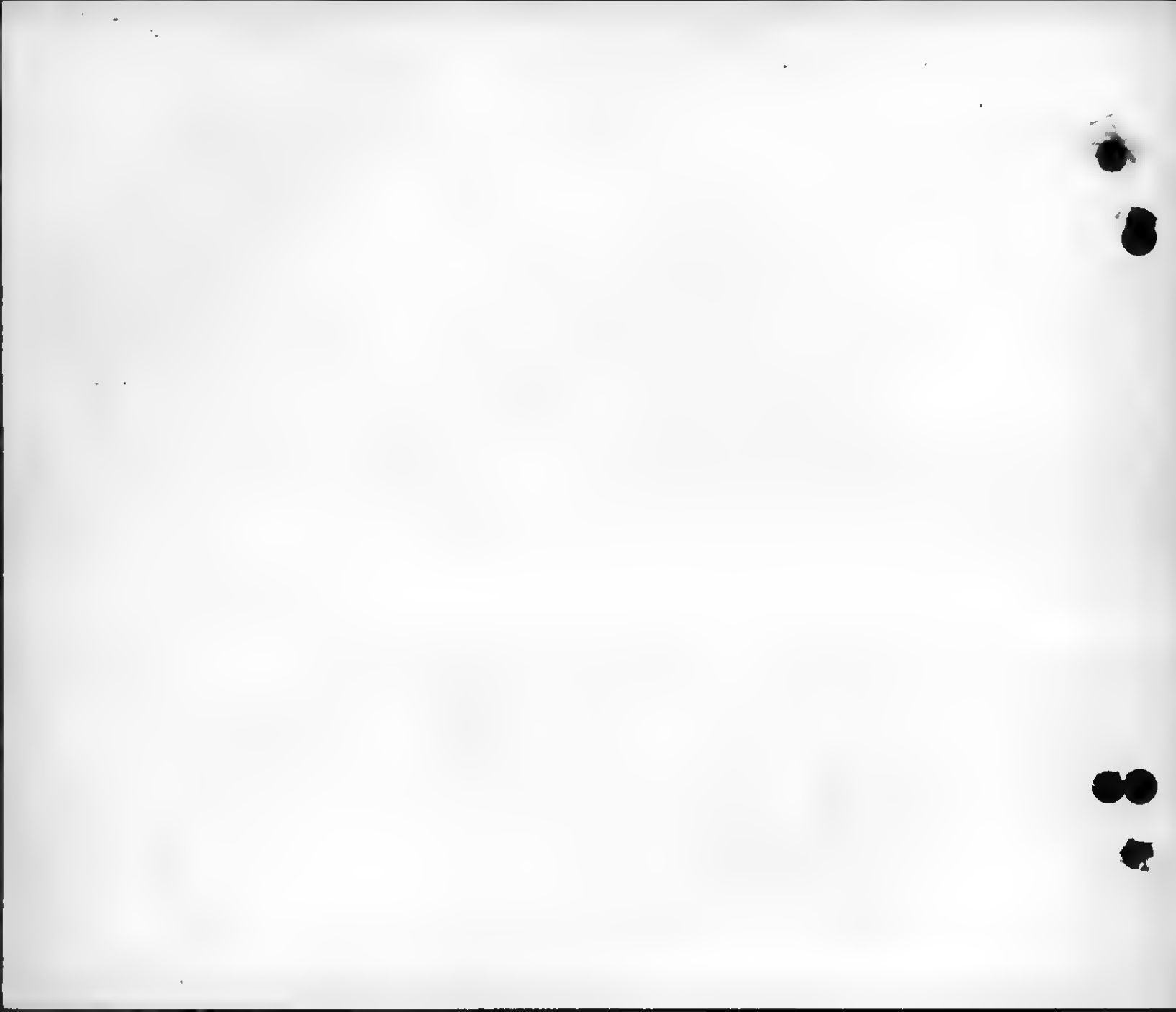
ADDRESS

SCHWEINSBERG FUNERAL SERVICE

1126 W. Cross St. Balto. 30 Md.

MARGIN RESERVED FOR BUNDLING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6263

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

COUNTY

Howard

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Harover

LENGTH OF STAY (In this place)

10 1/2 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Box 195

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Howard

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harover (Rural)

STREET ADDRESS

(If rural give location)

Box 195

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Ernestine Wilhelmina Lang

4. DATE OF DEATH:

(Month)

(Day)

(Year)

June 2 1936

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH:

Feb 2 - 1892

9. AGE last birthday

64 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Storekeeper

10B. KIND OF BUSINESS OR INDUSTRY:

Grocery store

11. BIRTHPLACE (State or foreign country):

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Jacob Younst

14. MOTHER'S MAIDEN NAME:

Minnie Brunk

15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.):

(If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

218-32-4667

17. INFORMANT & ADDRESS:

Albert A. Lang (husband) Box 195, Harover, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

32 X

IMMEDIATE CAUSE

(A)

Apollexy

ANTECEDENT CAUSE (S):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Arterial hypertension 3 yrs

(C)

General arterio sclerosis 3 yrs

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

1st stroke

INTERVAL BETWEEN ONSET AND DEATH

15 min

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED White ☐ Not white ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 31, 1934, to June 2, 1936, that I last saw the deceased

alive on June 1, 1936, and that death occurred at 3 P.M. from the causes and on the date stated above.

SIGNATURE

D. B. Brumbaugh

ADDRESS

M.D.

5609 Main St ElkrIDGE 27 Md

DATE SIGNED

6/2/36

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

6/5/36

NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. Pk.

LOCATION (City, town, or county)

ElkrIDGE, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickerson & Sons - Balt 17

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6264

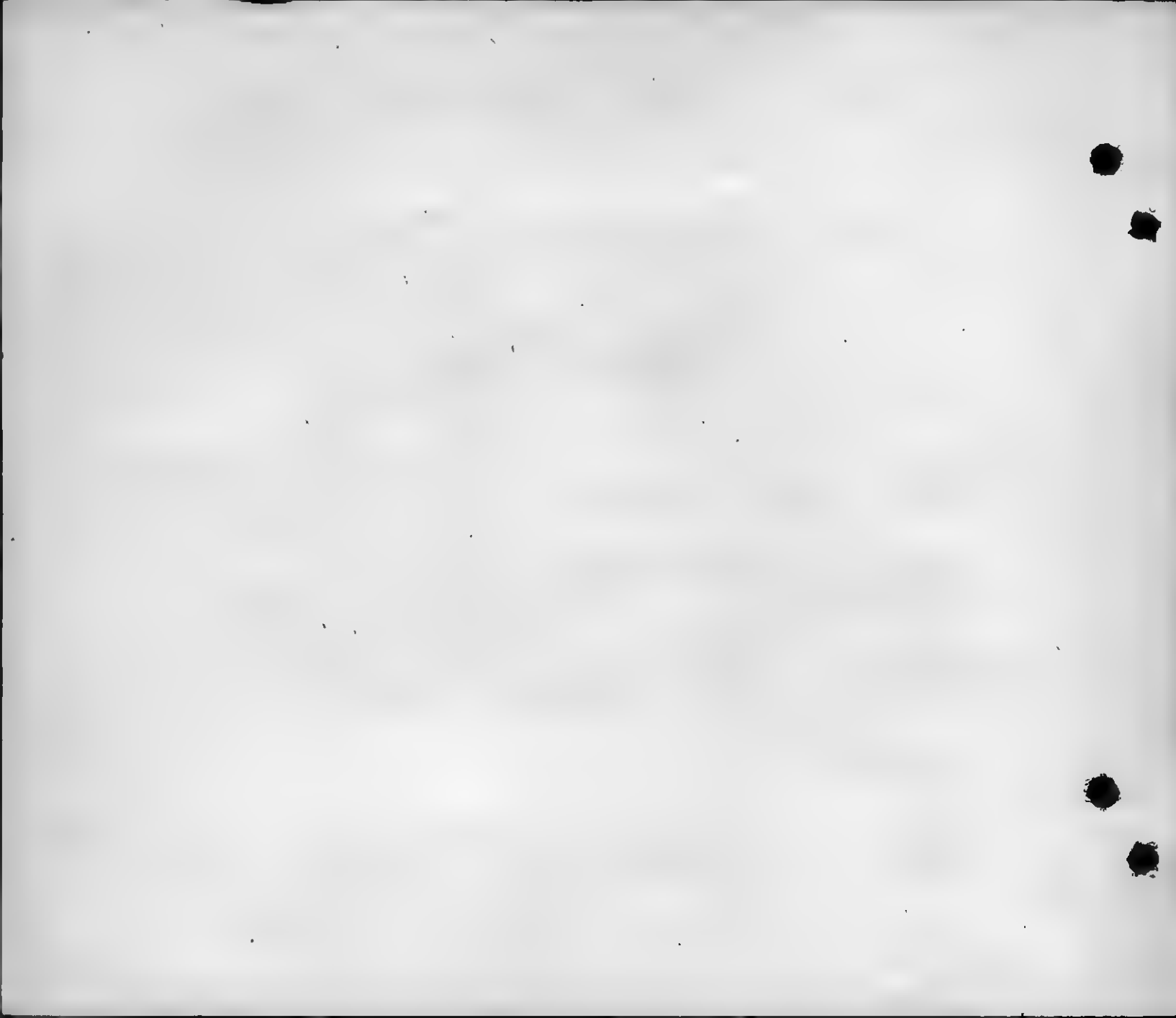
CERTIFICATE OF DEATH

Reg. Dist. No. 19C

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Elkridge, Rural</u>	<u>5 yrs</u>	TOWN <u>Elkridge, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Duckett Lane</u>		STREET ADDRESS (If rural give location) <u>Duckett Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>William H. Madden</u>		<u>June 5 1936</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cot</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married July 8-1937</u>	8. DATE OF BIRTH: <u>Aug 18 1887</u> 9. AGE last birthday: <u>78</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	11. BIRTHPLACE (State or foreign country): <u>Elkridge, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>James Madden</u>		14. MOTHER'S MAIDEN NAME: <u>Harriet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Maudie Madden (wife) Elkridge, Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
440X IMMEDIATE CAUSE		<u>Chronic Myocarditis</u> <u>2 1/2 yrs</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>Exhaustion</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>General Arteriosclerosis</u>	
		DUE TO <u>Arterial Hypertension</u> <u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mch. 1936</u> to <u>June 5, 1936</u> , that I last saw the deceased on <u>June 5, 1936</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. B. Brumby</u>		DATE SIGNED <u>6/5/36</u>	
M.D. <u>3809 Main St Elkridge, Md</u>			
23. REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>W. A. Burial</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-7-36</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
REGISTRAR'S SIGNATURE <u>L.</u>		24. FUNERAL DIRECTOR <u>Elroy O. Wilson 1000 Beantley Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06255

CERTIFICATE OF DEATH

Reg. Dist. No. 194

6265

1. PLACE OF DEATH a. COUNTY HOWARD COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE, MD. (RURAL)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 9508-49th PLACE, COLLEGE PARK, MD.			
3. NAME OF DECEASED (Type or print) First PATRICIA Middle ANN Last McGOWAN				4. DATE OF DEATH Month JUNE Day 9th Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/1955		9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 8 Days 2 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE.....				10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR J. McGOWAN				14. MOTHER'S MAIDEN NAME JEAN L. McGOWAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ARTHUR J. McGOWAN (FATHER)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parasitosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spina bifida, meningitis, hydro- DUE TO (c) Cephalus				INTERVAL BETWEEN ONSET AND DEATH 2 months congenital			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 2, 1956 to June 9, 1956 , that I last saw the deceased alive on June 7, 1956 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CLARKSVILLE, MARYLAND DATE SIGNED 6/9/1956							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				CLARKSVILLE, MARYLAND			
PHYSICIAN'S NAME (Type) DR. WHITTAKER, M.D.				CLARKSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/1956		22c. NAME OF CEMETERY OR CREMATORY ST. MARYS CATHOLIC CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOY COMPANY 1300 N. STREET, N.W.				24a. REC'D BY REGISTRAR WASH. D.C. 6-11-56		24b. REGISTRAR'S SIGNATURE Marie G. Whitaker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 144		d. STREET ADDRESS Route 144	
3. NAME OF DECEASED (Type or print) First Middle Last AMBROSIA H. OSTER		4. DATE OF DEATH Month Day Year June 16 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Garden, Indiana		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Hurst		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Philip Oster, West Friendship, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x DUE TO (b) NEPHROSCLEROSIS (c) 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITIS 20 YRS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18, 1942 to 6/16, 56 , that I last saw the deceased alive on 6/15, 1956 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker M.D.			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D. CLARKSVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-19-56	22c. NAME OF CEMETERY OR CREMATORY Mc Kendree	22d. LOCATION (City, town, or county) (State) West Friendship
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE 6-18-56	24b. REGISTRAR'S SIGNATURE Maria A. Whitaker

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE

PLACE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

DIAGNOSIS

TESTS

TREATMENT

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF WITNESS

SIGNATURE

DATE

PLACE

STATE

DEATH CERTIFICATE NO.

FILE NO.

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

BUREAU V. S.

JUN 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6267

CERTIFICATE OF DEATH

06257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glenwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glenwood</u>			
c. LENGTH OF STAY IN 1b <u>5 years</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>E</u> Last <u>YOUNG</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Abraham Porter</u>				14. MOTHER'S MAIDEN NAME <u>Unk -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ben Young - Glenwood, Md. Son.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, coronary thrombosis.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 Feb 56</u> <u>6 June 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>56</u> to <u>June</u> 19 <u>56</u> , that I last saw the deceased alive on <u>16 May</u> 19 <u>56</u> , and that death occurred at <u>7</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E Hall</u>				ADDRESS (Street, city or town, state) <u>Spruville, Md</u>			
DATE SIGNED <u>6 June 56</u>							
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		22d. LOCATION (City, town, or county) (State) <u>Brooksville Howard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Hykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. W. Madrick</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 11 1956

RECEIVED